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info@marketpublishers.com

Physician Views: Can new biologic therapies expand the severe asthma market?

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Abstracts

Looking to build on the success of Roche and Genentech's Xolair franchise, a clutch of biologic therapies being developed for the treatment of severe asthma are expected to move from the clinic to the regulatory and commercial arenas over the next few years.

Analysts are suitably expectant, as are developers, with there being some suggestion that the patient population eligible for treatment with these compounds will expand significantly beyond those who are refractory to inhaled therapies, as is the case at present, should efficacy data continue to impress.

Data presented at the recent American Thoracic Society (ATS) meeting showcased the efficacy profiles for a number of candidate products, such as GlaxoSmithKline's mepolizumab and AstraZeneca's benralizumab, both of which are anti-IL5 antibodies.

While it is difficult to compare products at this stage of development, it appears feasible that GlaxoSmithKline and AstraZeneca will look to exploit subtle differences in the efficacy profiles of their drugs in a bid to differentiate against each other and rival products from the likes of Teva and Roche.

For example, it remains to be seen whether a product that delivers superior data for exacerbation reduction will gain traction at the expense of a rival that may not be quite so strong in this respect, but which delivers more compelling data along secondary endpoints or quality-of-life measures. Furthermore, with biologic therapies administered either via a subcutaneous injection or intravenously, how significant could less frequent dosing prove to be? AstraZeneca, for example, is seeking to develop benralizumab for administration once every two months, versus once-monthly dosing for GlaxoSmithKline's mepolizumab.

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With late-stage data for these products poised to garner more attention over the coming months, FirstWord is polling US and EU5-based pulmonologists to ascertain their expectations and considerations for emergent biologic therapies in the severe asthma space. Specifically we asked them...

> What proportion of asthma patients they classify as being 'severe' sufferers who are eligible for treatment with either currently available or future biologic therapies (including non-refractory patients if necessary)?
>
> Whether they would be willing to sacrifice any benefit in exacerbation reduction for improved secondary considerations (such as FEV-1 asthma control scores and ACQ-6 asthma control scores) in a typical severe asthma patient being treated with a biologic therapy?
>
> Whether, and to what extent, quality-of-life measures will be more important than secondary efficacy measures for differentiating new biologic therapies for severe asthma?
>
> What level of advantage, if any, reduced dosing frequency would provide for a biologic severe asthma therapy?
>
> Based on their experience and knowledge of the use of biomarkers to tailor therapeutic approaches, how prepared they feel for a potential enhancement of this approach for the treatment of severe asthma with biologic therapies?

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